Constituent Services Guide

Illinois Department of Healthcare and Family Services

Office of Legislative Affairs
217-782-1212

2013

Contents

Introduction

The Illinois Department of Healthcare and Family Services (HFS) is responsible for providing healthcare coverage for adults and children who qualify for medical benefits, and for providing Child Support Services to help ensure that Illinois children receive financial support from both parents. The agency is organized into two major divisions, Medical Programs and Child Support Services. The Office of Inspector General is maintained within the agency but functions as a separate, independent entity reporting directly to the Governor's Office.

This guide provides an overview of HFS programs, and where legislative staff may seek assistance for constituents.

The Department of Human Services (DHS) is responsible for conducting eligibility determinations for most of the individuals receiving medical benefits from HFS. Therefore, most inquiries regarding eligibility have to be handled by DHS. This is particularly true over the next year in implementing the Affordable Care Act (ACA). The ACA implementation will include an expanded population, new eligibility policies and a new computer system for many benefits. As part of this implementation, there will be a new public-facing application for Medicaid, Supplemental Nutrition Assistance Program (SNAP) (food stamps), the LINK card, and some other forms of cash assistance called ABE (Application for Benefits Eligibility). Beginning October 1st, 2013, this can be accessed at ABE.illinois.gov.
Additionally:

- Day care assistance and programs formerly administered by the Department of Mental Health and Developmental Disabilities (DMHDD), the Division of Alcoholism and Substance Abuse (DASA) and the Department of Rehabilitation Services (DORS) should be directed to the Department of Human Services Legislative Office at 217-557-1551. Constituents can be directed to the DHS Helpline at 1-800-843-6154.

- Inquiries regarding the Illinois Health Insurance Marketplace, where people can buy private insurance, in many cases at subsidized rates, should be directed to the Illinois Department of Insurance at 877/527-9431.

- Inquiries regarding Medicare should be directed to the Social Security Administration at 800/MEDICAR(E).

Additional information regarding the HFS programs can be found on the department Website. See Page 23 for a quick reference guide to HFS vs. DHS responsibilities.

Office of Legislative Affairs

The Office of Legislative Affairs assists with inquiries regarding general department policies and procedures and individual constituent concerns. The information in this guide is provided to assist you with quick resolutions to your inquiries.

HFS operates under a number of laws that restrict its ability to release personal information, about its clients and applicants, for its programs. For this reason, inquiries, about clients or applicants, must be authorized by the individual or a person who has legal authority to act on the person's behalf. A form that may be used by individuals to authorize the release of personal health information is available on the HFS Website (www.hfs.illinois.gov/hipaa/) through using the HFS 3806D Authorization to Disclose Health Information (also included on page 21).

For all inquiries, the more information obtained, the quicker the response to the inquiry.

For most constituent inquiries, the following information is needed:

- Name of constituent
- Social Security number, recipient identification number, date of birth
- Provider/tax ID # (for provider inquiries)
- Address
- Full explanation of inquiry
- Names of third parties involved
- Authorization to disclose health information/HIPAA form for medical-related inquiries (pg 21)

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Child Support Services

Healthcare and Family Services Division of Child Support Services serves Illinois residents regardless of income. Services include parent locating services, paternity testing, child support order establishment and order modification reviews, medical support, wage withholding, computerized accounting and billing. HFS has numerous collection remedies, including interception of federal and state income tax refunds.

Tax Protests

Each year, the department sends thousands of notices of intent to intercept the tax refunds of noncustodial parents (NCP) to satisfy delinquent accounts. The NCP can protest this action by providing copies of court orders and Circuit Clerk payment ledgers. Upon completion of the department's review, the NCP will be notified in writing of the results and will be given the opportunity to appeal the decision.

Custodial Parent Inquiries

The department responds to inquiries from the custodial parent (CP) concerning many aspects such as status of enforcement, request for modification of the order, non-receipt of payments, locating absent parents, etc.

Noncustodial Parent Inquiries

HFS also receives inquiries from the Noncustodial Parent Inquiries (NCP). Most of these inquiries involve tax intercept notices and/or interception of the tax refund. Also, inquiries are received pertaining to account balances, non-credit of payments, incorrect service of income withholding orders, etc. *Due to confidentiality, the department cannot release certain information, such as the address of the CP to the NCP.*

Interstate Cases

The department maintains out-of-state cases where either the custodial parent or the non-custodial parent resides in another state.

Collection Remedies

Child Support's most effective way to collect child support is through the income withholding process, or wage garnishment. But the department also currently uses the following to collect delinquent child support:

- wage garnishment
- bank account seizure
- property lien
- professional license revocation
- passport revocation
- private collection agency
- credit bureau referral
- lawsuit probate and estate settlements
- workman's comp settlements
- federal and state income tax refund intercept
- lottery winning intercept
- driver's license suspension

Additional information is available on the department's Child Support Enforcement Website. (www.childsupportillinois.com)

Child Support Contact Information

Child Support Call Center: 800-447-4278
TTY: 800-557-5538
Drivers License Suspension Public Use: 217-524-2936

The Affordable Care Act

(Also known as Obamacare and Healthcare Reform)

The Affordable Care Act was signed into law on March 23, 2010; its major provisions go into effect on January 1, 2014. The principal goal of the law is to ensure that all Americans have essential health insurance coverage by:

- Creating health insurance marketplaces in every state so individuals and small businesses can compare and purchase private health plans that meet certain quality standards;
- Providing financial help through premium subsidies and cost-sharing reductions to help low and middle-income people afford plans offered in the Marketplace;
- Encouraging states to expand Medicaid; (which IL did with SB26)
- Encouraging states to create online application systems for multiple programs; and
- Setting requirements on private health insurance coverage
    - Bars exclusion from a plan because of a pre-existing condition;
    - Ends annual and lifetime caps on healthcare coverage

Illinois expanded its Medicaid program through SB26 to include coverage for adults without children and former foster care children. These changes go into effect on January 1, 2014.

Illinois has joined with the federal government to operate a Federal-State Partnership Health Insurance Marketplace. The Federal Government will manage the Marketplace and contract with the insurance companies. Open enrollment for the Marketplace begins October 1, 2013 and coverage begins January 1, 2014. An online application will make it easy and convenient to apply and enroll in a plan and can be completed at home, over the phone or with the help of trained community members, known as "Assisters." The online application will provide information on all of the available Qualified Health Plans (QHP) so individuals can directly compare and select a plan. It will also calculate the amount of financial help available based on income and family size.

The State has a number of Marketplace responsibilities: 1) consumer outreach, education and marketing; 2) reviewing and recommending QHPs for approval by the federal government; 3) training those who will "assist" individuals who apply; and 4) developing a website and Resource Center that will help direct people to the proper program. Through this "landing page" website, people likely to need to access the Marketplace will be directed to the Marketplace application; those more likely to qualify for Medicaid will be directed to ABE (Application for Benefits Eligibility), the new Illinois online application for the public. In addition, Illinois is planning to establish a Resource Center to answer people's questions and direct them to the proper program.

This summer the Illinois Health Insurance Marketplace will launch a significant marketing and consumer outreach campaign to encourage all eligible Illinoisans to access the new, affordable healthcare coverage options available. With healthcare coverage, everyone will receive the healthcare services they need, when they need it, leading to a healthier State.

Medical Programs

HFS provides healthcare coverage for adults and children who qualify for means-tested medical benefits. Eligible persons include children, parents, pregnant women, low-income senior citizens, individuals with disabilities, elderly in nursing facilities and people struggling with catastrophic medical bills.

Medical Eligibility Groups

Eligibility requirements vary as described below. Individuals may apply for most medical benefits online through the Department of Human Service's Apply For Cash, SNAP (Food Stamps) & Medical Assistance Web page. They may also apply in person at any of the Department of Human Services (DHS) Family Community Resource Centers across the state, or may send an application by mail. HFS also accepts applications directly for a number of the groups, as described in each section below. HFS and DHS jointly are developing a modern new Integrated Eligibility System which, beginning October 1st, 2013, will make it easier to apply for benefits online through a new client website called ABE (Application for Benefits Eligibility). After October 1st, 2013, all applications, even for Seniors and Persons with Disabilities, should be submitted on ABE.

Starting later this summer, the Illinois Health Insurance Marketplace will launch a significant campaign to direct clients to a specific website (to be developed) that will provide information on applying for Medicaid or for applying to the Illinois Health Insurance Marketplace to purchase private insurance, often at subsidized rates. Screening questions which identify clients more likely to need Medicaid will route applicants automatically to ABE.

Seniors and Persons with Disabilities (SPD)

SPD was also known as AABD (Aid to the Aged Blind and Disabled). Seniors, persons who are blind and persons with disabilities, with income up to 100 percent of the federal poverty level (FPL) ($958 a month for a single individual plus a $25 income disregard) and no more than $2,000 of non-exempt assets (for one person), can receive medical coverage. The state receives federal matching funds under Medicaid for these individuals. More information on how to apply for these programs may be found on the Department of Human Services Apply For Cash, SNAP (Food Stamps) & Medical Assistance Web page. There are copayments for most services. Individuals covered by Medicare A or B will receive most prescriptions through Medicare Part D and not the state medical card.

Family Health Plans

The All Kids and FamilyCare programs are comprised of five plans. Children are eligible through 18 years-of-age. Eligible adults must be either a parent or caretaker relative with a child under 19 years-of-age living in their home or a pregnant woman. A new group of adults will be covered under the Affordable Care Act – low-income adults without eligible dependent children (see Newly Eligible Adults under the ACA).

FamilyCare eligibility is 133 percent of the Federal Poverty Level (FPL), or $2,610 per month for a family of four. For all plans, persons must live in Illinois. Adults

must be U.S. citizens, legal permanent residents in the country for a minimum of five years, or have other qualifying legal immigration status. Children and pregnant women are eligible regardless of citizenship or immigration status. For more information visit the All Kids and FamilyCare Websites.

The All Kids Website is maintained to provide easily accessible and current information about the program. Families may apply for All Kids, FamilyCare and Moms & Babies online through both an English and Spanish Web-based application. Both English and Spanish applications are also available for download, by persons who want to apply by mail. Information is provided about income guidelines, cost sharing, and All Kids Application Agents that are available to assist families to apply.

FamilyCare/All Kids Assist

This program provides a full range of health benefits to eligible children 18 years-of-age and younger, and their parents or caretaker relatives. To be eligible, individuals must have countable family income no more than 133 percent of the FPL ($2,610 per month for a family of four). Families do not pay premiums. FamilyCare Assist parents have co-payments of $3.90 per medical service and $3.90 or below for brand name prescriptions received. No co-payments apply to children.

"Newly Eligible" Adults under the Affordable Care Act (ACA)

As of January 1, 2014, low-income adults, age 19 through 64, without dependent children who meet citizenship/immigration requirements will be eligible for Medicaid under ACA. (In Cook County, these adults are already covered in 2013 under a special waiver granted by the federal government, called CountyCare). To be eligible, monthly income can be up to 138 percent of the Federal Poverty Level ($1,321 for one person, $1,784 for a couple in 2013). There is no asset test. The health benefits package available to the group of adults will be similar to that offered to adults in FamilyCare.

All Kids Share

This program provides a full range of health benefits to eligible children. To be eligible, children must be in families with countable income of over 133 percent and at or below 150 percent of the FPL (between $2,611 and $2,944 a month for a family of four). Children in All Kids Share have a $3.90 co-payment for each medical service and $2 to $3.90 for brand name prescriptions received and $3.90 per day for inpatient hospital services, up to a maximum of $100 per family per year. There are no co-payments for well-child visits and immunizations. Children who are American Indians or Alaska Natives do not pay co-payments. There are no premiums for All Kids Share.

All Kids Premium Level 1

This program provides a full range of health benefits to eligible children. To be eligible, children must be in families with countable income over 150 percent and at or below 200 percent of the FPL (between $2,945 and $3,925 a month for a family of four). Families with children eligible for All Kids Premium Level 1 pay monthly premiums of $15 for one, $25 for two, $30 for three, $35 for four, and $40 for five or more children. All Kids Premium Level 1 families have a $3 or $5 co-payment for each medical service or prescription received and $5.00 per day for inpatient

hospital services, up to a maximum of $100 per family per year. Children must pay $25 for using the emergency room in a non-emergency, and there are no co-payments for well-child visits and immunizations. Children who are American Indians or Alaska Natives do not pay premiums or co-payments.

All Kids Premium Level 2

This provides a full range of health benefits to eligible children in families with income above 200 percent and at or below 300 percent of the FPL (between $3,926 and $5,888 a month for a family of four). Monthly premiums are $40 for one child and $80 for two or more children. Children must pay $30 to visit the emergency room. Co-payments vary by service, for example, the co-payment for a physician visit is $10, and prescriptions range from $3 to $7.

All Kids Rebate

This program will be eliminated on December 31st, 2013; applications will no longer be accepted as of October 1, 2013, since families will be eligible for subsidized private health Insurance by the Illinois Health Insurance Marketplace. Until January 2014, this provides children with full or partial reimbursement of premium costs, up to $75 per person per month, for private or employer-sponsored health insurance coverage of eligible family members. To be eligible, children must have countable family income over 133 percent and at or below 200 percent of the FPL (between $2,611 and $3,925 a month for a family of four). To qualify, they must have health insurance that covers physician and inpatient hospital care. Co-payments and premiums for All Kids Rebate are determined by the requirements of the family's private health insurance.

Moms & Babies

This program provides a full range of health benefits to eligible pregnant women and their babies up to one year of age. To be eligible, pregnant women must have countable family income, at or below 200 percent of the FPL, (at or below $3,925 a month for a family of four). Babies under one year of age are eligible at any family income level, as long as Moms & Babies covered their mother at the time of the child's birth. Moms & Babies enrollees have no co-payments or premiums and must live in Illinois.

Children Who Are Wards of the State

Comprehensive medical coverage, including oral health care, is provided to children whose care is subsidized by the Department of Children and Family Services (DCFS) under Title IV-E (Child Welfare) of the Social Security Act, as well as children served by DCFS through its subsidized guardianship and adoption assistance programs. Federal matching funds are available under Medicaid for nearly all these children. More information on DCFS programs may be found on DCFS website.

Former Foster Children – New Category

Also, on January 1, 2014, young adults older than 18 but younger than age 26 who were enrolled in Medicaid in Illinois when they aged out of foster care (anytime between the ages of 18-21) will be eligible for medical benefits regardless of income.

Health Benefits for Persons with Breast or Cervical Cancer (BCC)

This provides a full range of health benefits to uninsured persons, at any income level, who need treatment for breast or cervical cancer. Beginning October 1, 2007, the program was expanded to cover all uninsured persons in need of treatment regardless of income. The Department of Public Health provides screenings for breast and cervical cancer for uninsured women age 35 to 64. HFS administers the treatment portion of the program. Individuals seeking assistance should call the DPH Women's Health Line 1-888-522-1282 (1-800-547-0466 TTY). The Women's Health Line will be able to walk women through the eligibility requirements, and the screening process. Those who are already receiving coverage under the treatment portion of the program may call the department's BCCP Unit at 1-866-460-0913 (1-877-204-1012 TTY).

With no bar for pre-existing medical conditions under the ACA, women with healthcare needs will be able to buy private health insurance on the Illinois Health Insurance Marketplace.

Health Benefits for Workers with Disabilities (HBWD)

This program covers persons with disabilities who work and have earnings up to 350 percent of the FPL ($3,351 a month for a single individual net income after deductions for taxes, employment expenses and income disregards), who buy-in to Medicaid by paying a small monthly premium. Eligible people may have up to $25,000 in non-exempt assets. Retirement accounts and medical savings accounts are exempt. Federal matching funds are available, under Medicaid, for these benefits. Comprehensive program information, as well as a downloadable application, can be found on the Health Benefits for Workers with Disabilities Website.

Illinois Healthy Women (IHW) Program

The Illinois Health Women Program provides family planning (birth control) and reproductive health care services to low-income women, (up to $1,915 a month for a single individual), who qualify. Federal matching funds are available, at the 90 percent enhanced rate, for family planning services. Individuals may learn more on the Illinois Healthy Women Website.

With the expansion of Medicaid to cover all low-income adults, as well as the financial help available to buy private health insurance coverage through the Health Insurance Marketplace, HFS will help program participants transition to more comprehensive health coverage through one of these options so that all of their medical needs can be covered.

Medicare Cost Sharing

This covers the cost of Medicare Part B premiums, coinsurance, and deductibles for Qualified Medicare Beneficiaries, with incomes up to 100 percent of the FPL ($958 per month plus a $25 income disregard for one person). It covers the cost of Medicare Part B premiums only, for persons with incomes up to 135 percent of the FPL only, if they are Specified Low-Income Medicare Beneficiaries or Qualifying Individuals (up to $1292 per year plus a $25 income disregard for one person).

Assets are limited to $7,080 for a single person and $10,620 for a couple. The federal government shares in the cost of this coverage.

Spenddown

The spenddown program helps some people who have too much income or too many resources to qualify for medical benefits under the Seniors and Persons with Disabilities Program. The spenddown program for FamilyCare/All Kids recipients will be eliminated December 31st, 2013. Resources are not counted for Family Health Plans. Spenddown for adults in these plans will be discontinued at the end of 2013 as these adults will have access to affordable health insurance as a result of the ACA. Spenddown will not be available for the "newly eligible" adults under ACA.

Spenddown works a little like an insurance deductible. The person pays for the cost of their medical care up to a set amount each month based on their income and resources. This is called the spenddown amount. Once the medical expenses equal or exceed the monthly spenddown amount, HFS will cover allowable medical services for the rest of the month.

Most seniors and persons with disabilities who are approved for a spenddown case may enroll in the Pay-in Spenddown option. Pay-in Spenddown allows persons to pay their spenddown amount to HFS, rather than having to accumulate bills and receipts for medical expenses on a monthly basis and provide them to the DHS office. Monthly statements of the spenddown amount are issued to the client providing the opportunity to meet spenddown through money order, cashier's check, debit or credit card payment. Additional information on the spenddown program can be found on the HFS 591SP Medicaid Spenddown Web page.

State Hemophilia Program[1]

This program provides assistance to eligible patients to obtain antihemophilic factor, annual comprehensive visits and other outpatient medical expenses related to the disease. Participants must complete a financial application each fiscal year, and some participants may be responsible for paying a participation fee prior to the program paying for eligible services. Participation fees are determined by the individual's family income and family size. The program is always the payer of last resort, meaning that it only pays after other third party payers, such as private insurance or Medicare, have made a benefit determination. Participants cannot be eligible for regular medical benefits. Effective January 1, 2014, the hemophilia program will coordinate with the Marketplace to enroll eligible individuals and support the additional costs of treatment. Additional information about the State Hemophilia Program can be found in the HFS Medical Provider Handbook Chapter 100.

State Renal Dialysis Program[1]

This program covers the cost of renal dialysis services for eligible persons, who have chronic renal failure, and are not eligible for coverage under regular medical benefits or Medicare. Eligibility for the program is reviewed and determined on an

[1] Services are specific to program and do not cover a comprehensive array of health services.

annual basis. Participants must be a resident of Illinois, and meet citizenship requirements. The program assists eligible patients who require lifesaving care and treatment for chronic renal disease, but who are unable to pay for the necessary services on a continuing basis. The program covers treatment in a dialysis facility, treatment in an outpatient hospital setting and home dialysis, including patients residing in a long-term care facility. Individuals determined eligible for the program may be responsible for paying a monthly participation fee based on family income, medical expenses and liabilities, family members, and other contributing factors. All participation fees are paid directly to the dialysis center that provided the treatment. Effective January 1, 2014, the renal dialysis program will coordinate with the Marketplace to enroll eligible individuals and support the additional costs of treatment. Individuals may learn more or download an application on the State Chronic Renal Disease Program Website.

State Sexual Assault Survivors Emergency Treatment Program[1]

This covers emergency outpatient medical care expenses, and 90 days of related follow-up medical care, for survivors of sexual assault. The program covers: the initial emergency room (ER) visit; two follow-up visits in the hospital's emergency room within six weeks of the initial ER visit, and; follow-up care, related to the assault for 90 days following the initial ER visit, obtained from any community provider of the survivor's choice. The department maintains an online registry for hospitals to register the sexual assault survivor, in order to produce a voucher that allows the survivor to obtain the follow-up care. The program is always the payer of last resort, meaning that it only pays after other third party payers, such as private insurance or Medicare, have made a benefit determination. Participants cannot be eligible for regular medical benefits. Additional information about this program can be found on the HFS Website under the HFS Medical Provider Handbook Chapter 100.

Veterans Care

This provides comprehensive healthcare to uninsured veterans, under age 65, who were honorably discharged from the military, are income eligible, and are not eligible for federal healthcare through the U.S. Veterans Administration. Eligible individuals pay a monthly premium of either $40 or $70, depending on their income. By the end of fiscal year 2013, over 1,000 Illinois veterans had been approved for coverage at an average monthly premium of $40. Veterans may apply for Veterans Care by either downloading an application from the Website, or by going to their local Illinois Department of Veterans Affairs Office. The Department of Healthcare and Family Services determines eligibility, notifies the veteran and handles the premium payments. More information about Veterans Care is available on the Illinois Veterans Care Website.

Refugee Program

This covers persons who are not citizens, and who are not otherwise qualified, but who are admitted to the U.S. as refugees, asylees or conditional entrants; resident non-citizens who were formerly refugees; certain Amerasian immigrants from

[1] Services are specific to program and do not cover a comprehensive array of health services.

Vietnam; certain Cubans and Haitians; or victims of human trafficking. Eligible individuals are enrolled by DHS.

Medical Assistance for Asylum Applicants and Torture Victims

This provides up to 24 months coverage for persons who are not qualified immigrants, but who are applicants for asylum in the U.S., or who are non-citizen victims of torture receiving treatment at a federal funded torture treatment center. Such persons must meet all other eligibility criteria. Individuals may apply to DHS.

The Medicaid Service Delivery System Today

Currently, Illinois has three managed care delivery systems, Primary Care Case Management (PCCM), Voluntary Managed Care (VMC), and the Integrated Care Program (ICP).

Primary Care Case Management (PCCM)

The PCCM program is a mandatory state-wide program for most clients with the exception of those who choose to enroll in the Voluntary Managed Care program or those who are required to enroll in the Integrated Care Program. Over 1.8 million children and their parents are currently enrolled in the PCCM program, called Illinois Health Connect. Illinois Health Connect is based on the American Academy of Pediatricians' initiative to create medical homes to make sure that preventive healthcare is provided in the best setting. In Illinois Health Connect, clients have a "medical home" with a Primary Care Provider (PCP), such as a doctor's office. The PCP also provides care coordination and case management. For more information, visit the Illinois Health Connect Website or call Illinois Health Connect at the **Illinois Health Connect Helpline 877-912-1999.**

Voluntary Managed Care (VMC)

Under the Voluntary Managed Care program, over 240,000 parents and children have enrolled with a PCP in a Managed Care Organization (MCO). This program is operated by 2 managed care companies (MCO) and a Managed Care Community Network (MCCN) in 28 counties. (An MCCN is a provider-organized entity that accepts full risk, through a monthly capitated rate for each client, for all health-related services; the chief difference between a MCCN and an MCO is that the MCO is organized by an insurance company to accept full risk in paying for health care services, while an MCCN is organized by providers.) Clients that enroll in the VMC program get all of their services for the doctors and hospitals that are in the MCO network unless they get approval for the MCO. Clients may also get extra benefits for being a member of the MCO. For more information about the VMC program, visit the HFS website at Voluntary Managed Care Website.

Integrated Care Program (ICP)

Illinois has also implemented a mandatory managed care program called ICP. ICP is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventative care, effective evidence-based management of Chronic Health Conditions and coordination and continuity of care. This coordination

includes health services such as medical and behavioral health and also long-term supports and services. ICP is a mandatory program for over 40,000 older adults and adults with disabilities who are eligible for Medicaid but not Medicare. The ICP Program currently operates in suburban Cook (zip codes that do not begin with "606"), DuPage, Kane, Kankakee, Lake, Will Counties and on July 1, 2013 was expanded to include the counties of Henry, Boone and Winnebago. Over the next several months ICP will be expanded even more to include several counties in the Central Illinois Region, Metro-East Region and Quad Cities Region. For more information about ICP, visit the HFS Website at ICP Website.

The Medicaid Service Delivery System of the Future

In response to Medicaid Reform and the new era in care management, Illinois is in the process of expanding its managed care programs to include managed care entities: Coordinated Care Entities (CCEs), Accountable Care Entities (ACEs) and additional Managed Care Community Networks (MCCNs) and Managed Care Organizations (MCOs). Care coordination will be provided to most Medicaid clients by these new managed care entities, including the "new" Medicaid enrollees under the Affordable Care Act. Many of these new and expanded managed care programs will be implemented by the Department during calendar year 2013 and 2014 in order to meet the enrollment requirements of at least 50% of Medicaid clients being enrolled in care coordination by January 2015.

As Illinois expands managed care, eligible clients in most counties will have a choice of at least two managed care entities from which to receive care coordination services. Illinois is seeking waivers from the federal government to require mandatory enrollment in a managed care entity for both medical services (including behavioral health) and for long-term supports and services, in cases where those services are required (especially for Seniors and Persons with Disabilities).

Expanding managed care also means that Illinois will be transitioning from a fee-for-service system, with few restrictions on where or how to deliver or receive services – to a system where it will be expected that providers will work in a collaborative fashion to offer integrated healthcare services focused around the holistic needs of clients. This will require a change in operations for Medicaid clients, for Medicaid providers, and for state agencies which will have to break down the silos of government.

Care Coordination

Care Coordination is the centerpiece of Illinois' Medicaid reform - aligned with the 2011 Illinois Medicaid reform law (PA96-1501), the Medicaid Expansion Bill (SB26), and the federal Affordable Care Act. PA96-1501(also known as "Medicaid Reform") requires that 50% of Medicaid clients be enrolled in care coordination programs by 2015. Care coordination recognizes that Medicaid (and other payers) should not pay for quantity of medical procedures after people get sick, but should focus on the quality of healthcare to improve health outcomes. This is a new era in care management: keeping people healthy through better and more coordinated care, thereby saving avoidable, unnecessary healthcare costs.

Dental Program

Children enrolled in the All Kids program are covered for comprehensive dental care. Adolescents, age 19-20, in specific populations, including pregnant women, parents, and the developmentally disabled are also eligible for comprehensive dental services.

Effective July 1, 2012, adults (age 21 and over) are only covered for emergency dental services. These services are defined as a situation deemed medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can only be treated by extraction. With changes made by the Legislature, emergency treatment will also include situations where pregnancy, surgery or other medical complications require some dental treatment.
The cost of the dental exam, x-rays, and necessary sedation, as well as the extraction (s) will be paid by Medicaid if the emergency extraction process is completed with 14 days of the initial exam.

The All Kids and Medicaid Dental Programs are currently administered by DentaQuest of Illinois. Dental Program patients who have questions, including a need for a referral to a dentist, should contact DentaQuest by phone at 1-888-286-2447. Dental providers with questions, including billing inquiries, should call 1-888-281-2076.

More information regarding the HFS Dental Program may be obtained on the HFS Maternal and Child Health Dental and Oral Health Web page and the DentaQuest Website.

Non-Emergency Transportation

HFS ensures access to necessary medical care for participants enrolled under Title XIX (Medicaid), Title XXI (SCHIP) and All Kids Level 1 program, as required by the Social Security Act. In order to be in compliance with the Act, HFS pays for non-emergency transportation to and from covered services for these participants. A covered service is defined by the department as a medical service for which the department can make payment.

Non-emergency transportation requires prior approval. Under the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), First Transit, Inc. is responsible for the screening of all non-emergency transportation for prior approval. The request for non-emergency transportation must be made by calling First Transit, toll-free, at: 1-866-503-9040 (TTY: 1-630-873-1449 for the hearing impaired) 8 a.m. to 5 p.m. - Monday through Friday (closed on state holidays). The call can be made by the covered participant, their representative, or the medical provider.

Home and Community Based Services (HCBS) Waivers

A waiver is a program that provides services that enable individuals that otherwise would be eligible for nursing home or institutional care to remain in their own home, or live in a community setting. Illinois has nine Home and Community Based Services waivers (HCBS). Each waiver is designed for individuals with similar needs, and offers a specific set of services. All but two of the nine waivers include day-to-day operation by the Department of Human Services or Department on Aging. HFS directly administers the Supportive Living Program and coordinates with the Division of Specialized Care for Children (DSCC) on the Medically Fragile Technologically Dependent (MFTD) waiver. HFS provides oversight, program monitoring, fiscal monitoring, and administrative coordination to secure federal funding. The programs operated by sister agencies include the HCBS waivers for: Persons with HIV/AIDS, Persons with Brain Injury, Persons with Physical Disabilities, Adults with Developmental Disabilities, Children and Young Adults with Developmental Disabilities-Support, Children and Young Adults with Developmental Disabilities-Residential, all of which are operated by the Department of Human Services; Persons who are Elderly, operated by the Department on Aging, and the Medically Fragile Technology Dependent (MFTD) Children Waiver, case managed by the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC). Detailed information, including eligibility requirements and services for each of the waivers, can be found on the HFS Home and Community Based Services Waiver Programs Web page.

Prior Approval

For some medications and durable medical equipment (such as wheelchairs, prostheses, etc.), prior approval is required before the department will provide coverage. When prior approval is necessary, the prescribing physician, or the selected pharmacy or vendor, should request approval from the department. The client themselves cannot request approval. The physician, or pharmacy, must provide documentation of medical necessity before approval can be given. More information regarding prior approval can be found on the HFS Drug Prior Approval Information Web page.

Orthodontic services (braces) for children enrolled in the All Kids program, require prior approval from the Dental Program administrator (DentaQuest of Illinois). Orthodontists needing further information on the process should contact DentaQuest at 1-888-281-2076.

Office of the Inspector General

The Office of Inspector General (OIG) each year performs thousands of activities, including fraud prevention research and investigations, provider audits, quality of care reviews, Medicaid eligibility reviews, investigations of employees and contractors, recipient fraud investigations, new provider verifications and safety monitoring and special projects aimed at identifying and preventing fraud, waste and abuse in the Medicaid system.

The activities often lead to sanctions against Medicaid providers, recovery of overpayments, criminal actions, the restriction of recipients who abuse Medicaid privileges, and the development of new fraud initiatives. The OIG has also developed a state of the art predictive modeling system through federal grant funding from the Centers for Medicare and Medicaid Services ("CMS"). CMS has recently pronounced this system as a "Best Practice." The system adds to the OIG's capabilities to find, prevent and detect possible fraud within the Medicaid system.

The numerous areas within which the Office of Inspector General operates and the associated recoupment's, cost avoidance and savings, are delineated annually in the OIG's Annual Report available at the following website:
http://www.state.il.us/agency/oig

Constituents who need to report fraud can go to the Inspector General's website, http://www.state.il.us/agency/oig/reportfraud.asp or may call 888/557-9503.

Providers that need to verify the possible sanctions of an employee can go to:
http://www.state.il.us/agency/oig/sanctionlist.asp

Constituent Inquiries

General

Legislative staff is encouraged to help constituents use the resources described in this document for assistance. When these resources are not sufficient, legislative inquiries should be directed to the HFS' Office of Legislative Affairs.

Medical Provider Inquiries

The department processes thousands of Medicaid claims. Effective July 1, 2012, a claim will be considered for payment only if it is received by the department no later than 180 days from the date on which services or items are provided. Some claims may be rejected for payment for various reasons. The provider may call 877-782-5565, option 3, option 1, to contact a physician billing consultant. Providers may also contact you to investigate the cause of rejected payments or non-payment by the department. Information needed to research these inquiries is: the provider name and provider number (this is the all numeric, 12-digit number). Given the state budget problems, payment delays will be significant this year.

Unpaid Medical Bills

You may also receive inquiries from clients who are being billed for medical services. If it is determined that the client is not responsible for paying the bill, the department should be able to correct the problem. To investigate, the client's name, recipient ID number, dates of service, and name of provider sending the bill are needed.

Health Benefits Hotline

Health Benefits/All Kids Hotline (1-800-226-0768): The hotline is charged with serving Illinois residents by informing them of their healthcare options and helping clients resolve issues that may arise pertaining to their healthcare coverage. Staff regularly responds to inquiries relating to eligibility for medical benefits, including All Kids, FamilyCare, Illinois Healthy Women, Pay-In Spenddown, Veterans Care and Health Benefits for Workers with Disabilities (HBWD). The hotline also receives inquiries regarding covered services. Generally speaking, calls about the eligibility of clients whose cases are managed by the Department of Human Services must be referred to DHS.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) requires health care entities to adopt standards for electronic transactions, including data elements, standard code sets, unique health identifiers, security safeguards and privacy standards.

The release of personal information by the department shall be limited, according to Illinois law, to the state of Illinois government agencies and/or to authorized department contractors or grantees. If the department transmits personal information over the Internet, it will employ security measures, including, but not limited to, encryption, to ensure the privacy of the data (see next page for disclosure form that your office can use, or download from HIPAA Privacy Forms at www.hfs.illinois.gov/hipaa/).

State of Illinois
Department of Healthcare and Family Services

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NOTICE:

- Federal law says that Healthcare and Family Services (HFS) cannot share your health information without your permission except in certain situations. If you sign this form, you are giving HFS permission to share your health information that HFS has with the person you indicate below.
- This authorization is voluntary.
- **Right to Revoke:** If you decide you do not want HFS to share your health information any longer, sign the revocation at the end of this form and give this form to HFS. If HFS has shared your health information for a research study, HFS may continue to use or share your health information for that purpose only.
- Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- HFS cannot promise that the person you permit HFS to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact HFS privacy officer to get a copy if you do not have one.

My name (print) _____Date of birth_____

Social Security Number _____Recipient Identification Number _____

I give permission to **Healthcare and Family Services** to share my health information with:

_____
so that this person or entity may assist me with my health care issues.

HFS may share my health information for one year after the date on this authorization form or until I revoke the authorization.

I want HFS to share this health information: **(check all boxes that apply)**:

- ☐ All of my health information
- ☐ Information regarding prescription drug coverage
- ☐ My health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
- ☐ My health information regarding treatment for alcohol and/or substance abuse
- ☐ My health information regarding behavioral health services or psychiatric care
- ☐ Other _____

This form must be signed EITHER by the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Recipient _____Date _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a power of attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative _____Date _____

Relationship of Personal Representative_____
HFS 3806D (R-6-09)

REVOCATION OF AUTHORIZATION

I no longer want Healthcare and Family Services to share my health information with the person or entity indicated above.

My name (print) _____

Social Security Number _____

Signature _____ Date _____

Send this **Authorization Form** or **Revocation of Authorization** to:
Privacy Officer Healthcare and Family Services
P.O. Box 19159 Springfield, Illinois 62794-9159
Fax: 1-217-524-2397

If you have any questions, contact the Privacy Office at the address above, or the phone number below. The call is free. Toll-free telephone: 1-800-226-0768 (Health Benefits Hotline) Toll-free for persons using a TTY: 1-877-204-1012 e-mail address: privacy.officer@illinois.gov

Contact Information

Department of Healthcare and Family Services (HFS)

201 South Grand Avenue East
Springfield, IL 62763
217-782-1212
Fax: 217-524-0075

- Child Support Services
- All Medicaid policy issues
- Medicaid provider enrollment/payment problems
- All Kids/FamilyCare
- Integrated Care/Managed Care
- Health Benefits for Workers with Disabilities
- Illinois Breast and Cervical Cancer Program
- Veterans Care
- Pay-In Spenddown
- Illinois Healthy Women
- State Hemophilia Program
- State Renal Dialysis Program
- State Sexual Assault Survivors Emergency Treatment Program
- Home and community-based services for medically fragile and technology dependent children and Supportive Living Facilities
- Illinois Health Connect

Department of Human Services (DHS)

100 South Grand Avenue East
Springfield, IL 62762
217-557-1551
Fax: 217-557-1650

All applications and eligibility questions for the following should be submitted to DHS:

- Medicaid
- SNAP (food stamps)
- Cash assistance programs (TANF and AABD cash)
- LINK card
- All Kids Assist/ FamilyCare Assist
- Long term care
- Spenddown
- Daycare assistance
- Funeral & burial benefits
- Refugee services
- Mental health, Substance Abuse, Rehabilitation Services